# International Developments in Abortion Law from 1988 to 1998

*Rebecca J. Cook, JD, JSD, Bernard M. Dickens, PhD, LLD, and Laura E. Bliss, LLB*

ABSTRACT

*Objectives.* In 2 successive decades since 1967, legal accommodation of abortion has grown in many countries. The objective of this study was to assess whether liberalizing trends have been maintained in the last decade and whether increased protection of women's human rights has influenced legal reform.

*Methods.* A worldwide review was conducted of legislation and judicial rulings affecting abortion, and legal reforms were measured against governmental commitments made under international human rights treaties and at United Nations conferences.

*Results.* Since 1987, 26 jurisdictions have extended grounds for lawful abortion, and 4 countries have restricted grounds. Additional limits on access to legal abortion services include restrictions on funding of services, mandatory counseling and reflection delay requirements, third-party authorizations, and blockades of abortion clinics.

*Conclusions.* Progressive liberalization has moved abortion laws from a focus on punishment toward concern with women's health and welfare and with their human rights. However, widespread maternal mortality and morbidity show that reform must be accompanied by accessible abortion services and improved contraceptive care and information. (*Am J Public Health.* 1999;89:579–586)

A systematic review of national and international developments regarding abortion showed that the progressive liberalization of abortion laws between 1967–1977[1] and 1977–1988[2] generally has been maintained during the last decade. This article traces developments in national legislation, leading court decisions, and constitutional provisions on abortion worldwide and analyzes United Nations (UN) conference documents, observations made by the committees that monitor government compliance with international human rights conventions, and the interpretative literature since 1988.

Table 1 presents changes or clarifications in the legal indications for abortion since 1988, based on national legislation and judicial interpretations of legislation. (Citations for legislative and judicial developments may be found in the chart, unless otherwise cited.) Overall, 26 jurisdictions have extended grounds for lawful abortion, and 4 countries have restricted them. Table 1 does not include legal developments that affect the gestational limits on abortion, such as in the Russian Federation[3] or in the Seychelles[4]; that reduce the punishment for abortion, such as in Peru[5]; that codify the law, such as in Andorra[6]; in which the effect of the legal initiative is unclear, such as in Indonesia[7]; or in which there was a reform and then a subsequent suspension, such as in the Mexican state of Chiapas.[8]

Table 1 shows that liberalizing initiatives have been taken in all regions of the world. These findings are consistent with other studies reviewing legal trends over shorter[9] and longer[10] periods. This decade of legal developments contributed to and reflects the identification of abortion as a major public health concern at the International Conference on Population and Development,[11] which was held in Cairo, Egypt, in 1994, and the Fourth World Conference on Women, [12] which was held in Beijing, China, in 1995. In addition to reforms affecting legal indications for abortion, reforms affecting matters such as access to and availability of services, their cost and confidentiality, and the licensing of new abortifacient drugs are addressed.

Legal reforms reflect 3 different and often contradictory developments. The first shows the conventional use of law over several centuries as an instrument to express and enforce by criminal sanctions the moral prohibition of abortion. The second development addresses the harm to life and health experienced by women, infants, and families because of criminal barriers to therapeutic abortion and places abortion within a context of health and welfare. The most recent development places abortion within a spectrum of services to which women should have safe access as a matter of human rights and social justice.

## *Crime and Punishment*

The use of criminal law to control morality was reinforced by the constitutional courts in Colombia,[13] Germany,[14] and Poland.[15] The Colombian and Polish courts maintained restrictive abortion laws against attempts at liberalization. The Colombian court cited papal encyclicals to uphold criminal law protection of life from conception,[16] and the Polish court discussed protection of fetal life as a constitutional value. The German constitutional court held a 1992 liberal

Rebecca J. Cook and Bernard M. Dickens are with the University of Toronto Faculty of Law and Faculty of Medicine, and the Joint Centre for Bioethics, Ontario. Laura E. Bliss is with McCarthy Tétrault, Vancouver.

Requests for reprints and correspondence should be sent to Rebecca J. Cook, JD, JSD, University of Toronto, Faculty of Law, 84 Queen's Park, Toronto, Ontario, Canada M5S 2C5 (e-mail: rebecca.cook@utoronto.ca).

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law[17] unconstitutional.[18] The court decided that abortion must remain criminal to preserve the value of unborn life, but the state need not punish abortion that occurs within the first 3 months of pregnancy and after appropriate counseling.[19]

Countries subscribing to the 1995 Beijing Platform for Action have committed themselves to consider "reviewing laws containing punitive measures against women who have undergone illegal abortions."[20] Review would require countries that penalize women for undergoing abortions or attempting their own abortion, such as Chile[21] and Nepal,[22] to reform their respective laws. France eliminated penalties against women who induce their own abortions,[23] thus ensuring the legality of self-administration of abortifacient drugs. Mifepristone (RU 486) combined with prostaglandin was approved in France in 1988.[24] A mifepristone/prostaglandin combination was also licensed as an abortifacient in China,[25] Sweden,[26] and the United Kingdom,[27] but no criminal law reforms were initiated. Legislation was passed in Australia in 1996; however, all abortifacients were placed on the restricted drug list,[28] thus strictly limiting their distribution. In the United States, the Food and Drug Administration issued an "approvable" letter for mifepristone, accepting the drug to be safe and effective when used in combination with misoprostol (a prostaglandin) for the termination of early pregnancy. The Food and Drug Administration awaits additional information on other issues, including manufacture and labeling, before considering final approval.[29]

There is some support for criminal deterrence of sex-based abortion because of use of prenatal sex determination to facilitate abortion of female fetuses. Countries such as China[30] and India[31] have passed laws against fetal sex selection, except in prenatal testing for serious sex-linked disorders. The thrust of legislation is not necessarily to punish women as such, who may be considered victims rather than perpetrators of sex discrimination, but it is directed against medical and other providers who offer preconception, prenatal, and genetic services to favor pregnancies and births of children on the grounds of sex unrelated to sex-linked genetic disorders.

## *Health and Welfare*

The Cairo Programme committed countries to "deal with the health impact of unsafe abortion as a major public health concern."[32] The World Health Organization estimates that approximately 20 million unsafe abortions occur every year, resulting in 78 000 maternal deaths and hundreds of thousands of disabilities in women, the overwhelming majority of which occur in developing regions.[33] The health effects of legal denial of safe abortion services are dramatically illustrated by the severely repressive legislation of 1966 in Romania, which was reversed in 1989. Abortion-related maternal deaths per 100 000 live births rose from fewer than 20 in 1965 to between 120 and 150 in 1982 through 1989. As a percentage of maternal deaths from all causes, abortion-related deaths rose from about 20% to nearly 90%, and the rate of maternal mortality in Romania, which in 1966 was comparable to that of most other eastern European countries, was at least 10 times higher than in any other European country by 1989.[34] In contrast, in the year following legalization of abortion, the maternal mortality rate declined by almost 50%.[35]

Epidemic levels of unsafe abortion exist in Latin American countries with restrictive laws.[37] Every year, approximately 4 million Latin American women undergo unsafe abortions, and 30% to 45% experience complications, which imposes enormous costs on health care systems.[38] Guyana liberalized its abortion law in reaction to evidence of high rates of maternal mortality caused by unavailability of safe, legal abortion services.[38] A study on the health sector costs of unsafe abortion under the old, restrictive South African law was estimated in 1994 to be approximately $1.93 million.[39]

Legality of abortion alone is insufficient to reduce maternal morbidity and mortality rates associated with unsafe abortion. South Africa continues to struggle with unsafe abortions, despite the 1996 passage of a liberal abortion law that enables trained nurse midwives to perform early abortions.[40] A shortage of equipment, facilities, and qualified staff combined with resistance from doctors and other health care providers to assist in terminations mean that many women who qualify for legal abortion are turned away from designated facilities or are forced to wait up to 2 weeks for the procedure.[41]

Studies in India, where abortion on extended grounds has been legal since 1971, also indicate that faulty implementation of the law and a general lack of resources have resulted in a high incidence of unsafe abortion. In 1991 through 1992, only one third of eligible facilities were licensed to provide abortions, and most of these were located in urban centers.[42] Many of the licensed facilities do not actually offer abortion services because of shortages of trained personnel and equipment. In the state of Tamil Nadu, abortions are frequently contingent on acceptance of sterilization.[43]

In Turkey, where abortion has been legal since 1983, low-income women have limited access to safe abortion because abortions are primarily offered by costly private sector facilities.[44] However, research on the quality of public sector services has led the Turkish Ministry of Health to train health personnel and provide postabortion contraceptive counseling and services.[45]

Participants at the Cairo Conference agreed that abortion should not be promoted as a regular method of family planning and that "[p]revention of unwanted pregnancies must always be given the highest priority."[46] However, the World Health Organization estimates that one half of all pregnancies are still unplanned, and one quarter are unwanted.[47] Most of the developments in abortion law reform in the last decade removed criminal barriers to abortion, but few of these developments require the actual provision of abortion services and preventive measures designed to reduce the need for abortion, such as postabortion contraceptive counseling and services,[48] reproductive health information and services including emergency contraception, and sexuality education.

Locating abortion services within the context of health services has presented some countries that provide nationally funded health care with the need to distinguish between therapeutic and nontherapeutic abortions. In Canada, the proposal by the government of British Columbia to deny health insurance coverage for abortions was held unlawful because determining whether abortion is medically required is a clinical, not a political, decision.[49]

In the United States, since the "Hyde Amendment" was passed in 1976,[50] Congress has passed legislation every year prohibiting federal funding of abortion for low-income women, except in limited cases. Today, federal funding of abortion is limited to instances in which the woman's life is at stake or in which the pregnancy is the result of rape or incest.[51] However, over the past decade, several state courts have struck down statutes restricting abortion funding for low-income women.[52] President Clinton has twice vetoed bills passed by Congress banning so-called partial birth abortions for failing to have an exception for preservation of women's health. Further, every federal court of appeals that has so far ruled on the subject has found similar state statutes unconstitutional.[53]

## *Human Rights and Social Justice*

Protection and promotion of women's human rights under national and international law have gained significant momentum in the

**TABLE 1—Legislative and Judicial Developments in Indications for Abortions: 1988–1998**

| | Risk to Life of Woman | Risk to Woman's Physical Health | Risk to Woman's Mental Health[a] | Risk to Fetal Health or Fetal Handicap[b] | Unwanted Pregnancy by Rape or Other Sexual Crimes | Social, Sociomedical, or Socio-economic[c] | On Request[d] | Statutes and Year of Latest Enactment |
|---|---|---|---|---|---|---|---|---|
| Albania | X | L-22 wks. | L-22 wks. | X | L-22 wks. | L-22 wks. | L-12 wks. | 1995 (7 Dec) Law No. 8045 on the interruption of pregnancy |
| Australia (Western Australia) | X | X | X | X | | L-20 wks. | L-20 wks. | 1998 Acts Amendment (Abortion) Act |
| Belgium | X | X | X | X | | | L-3 mos. | 1990 (3 Apr) Law on Medical Termination of Pregnancy amending Penal Code, Art 348, 350,351, 352; repealing Art 353 |
| Botswana | X | L-4 mos. | L-4 mos. | L-4 mos. | L-4 mos. | | | 1991 (11 Oct) Penal Code (Amendment) Act |
| Bulgaria | X | L-5 mos. | L-5 mos. | X | | L-4 mos. | L-3 mos. | 1990 (1 Feb) Decree No. 2 |
| Burkina Faso | X | X | X | X | L-10 wks. | | | 1996 (13 Nov) Law No. 043/96/ADP, Sec. 3 |
| Cambodia | X | | | X | X | | L-3 mos. | Royal Kram No. NS/SKM/O196/06 (12 Nov 1997) |
| Canada | X | X | X | X | X | X | X | *R. v. Morgentaler* 44 DLR 4th 385 (1988) |
| Cayman Islands | X | | | | | | | 1989 Penal Code (Amendment) Act |
| Chile[-e] | ? | | | | | | | 1989 (24 Aug) No. 18.826 |
| El Salvador[-e] | ? | | | | | | | Penal Code, Decree No. 1030, Jan 20, 1998, Chap. II, §133-37. |
| Equatorial Guinea | X | X | X | | | | | 1991 (4 Apr) Act No. 1/1991 regulating abortions |
| Estonia[f] | X | L-20 wks. | | | | | L-12 wks. | 1992–3 Decrees 930402 and 930625 of Ministry of Social Affairs |
| Germany | X | X | X | | L-3 mos. | | L-3 mos. | 1995 (21 Aug) Assistance to Pregnant Women and Families Amendment Law |
| Guernsey | X | X | X | L-6 mos. | | L-3 mos. | | 1996 Abortion (Guernsey) Law |
| Guyana[f] | X | X | X | X | L-4 mos. | L-4 mos. | L-8 wks. | 1995 Medical Termination of Pregnancy Act, No. 7 |
| Hungary[f] | X | L-3 mos. | L-3 mos. | L-5 mos. | L-3 mos. | L-3 mos. | L-3 mos. | 1992 (17 Dec) Law No. 79; Ordinance No. 32 (23 Dec) of the Minister of Social Welfare |
| Ireland | X | | | | | | | *Attorney General v. X and Others* 1 IR 1 (SC 1992) |
| Isle of Man | X | X | X | L-6 mos. | L-3 mos. | | | 1995 Termination of Pregnancy (Medical Defenses) Act |
| Japan[-] | X | L-22 wks. | | | L-22 wks. | L-22 wks. | | 1991 Order of the Ministry of Health and Welfare. 1996 Maternal Protection Law No. 105 |
| Jersey | X | X | X | L-6 mos. | | | L-3 mos. | 1997 Termination of Pregnancy Law |
| Malaysia | X | X | X | | | | | 1989 (19 Apr) Act No. A727 to amend the Penal Code, s. 312 |
| Mongolia[f] | X | X | X | | | | L-3 mos. | 1989 (23 Dec) Decree No. 200 amending the Health Law, s. 56 |

*Continued*

last decade. Prominent among such rights are rights to reproductive health and self-determination, of which safe and dignified access to abortion services is an important part. The Committee on the Elimination of Discrimination Against Women (CEDAW), the body that monitors state compliance with the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention), and the Human Rights Committee, the monitoring body for the International Covenant on Civil and Political Rights (the Political Covenant), scrutinize government reports. CEDAW's concluding comments on reports, such as those from Morocco[54] and Namibia,[55] have described high rates of maternal mortality caused by clandestine abortions as violations of women's right to life and have recommended that governments review punitive measures and ensure women's timely lawful access to emergency care. The

**TABLE 1—*Continued***

| | Risk to Life of Woman | Risk to Woman's Physical Health | Risk to Woman's Mental Health[a] | Risk to Fetal Health or Fetal Handicap[b] | Unwanted Pregnancy by Rape or Other Sexual Crimes | Social, Sociomedical, or Socio-economic[c] | On Request[d] | Statutes and Year of Latest Enactment |
|---|---|---|---|---|---|---|---|---|
| Pakistan | X | X[g] | ?[g] | ?[g] | ?[g] | | | 1990 (Sep 5) Criminal Law Ordinance VII s.338 |
| Poland[-] | X | L-12 wks. | L-12 wks. | X | L-12 wks. | | | Act of 30 Aug 1996 as amended by Act of 23 Dec 1997 |
| Romania | X | X | X | X | X | | L-14 wks. | Art 185 of Penal Code 1998 |
| Saudi Arabia | X | L-4 mos | L-40 days[h] | L-40 days[h] | L-40 days[h] | | | 1989 (26 Jun) Ministerial Resolution No. 218/17/L of the Ministry of Health |
| South Africa | X | L-5 mos. | L-5 mos. | L-5 mos. | X | L-5 mos. | L-3 mos. | Choice on Termination of Pregnancy Act 92 (1996) |
| Sudan | X | | | | L-3 mos. | | | 1991 Penal Code Amendments |
| Vietnam | X | X | X | X | X | X | X | 1989 (30 Jun) Law on the Protection of People's Health |

*Note.* This chart covers legislative and judicial changes in abortion law from the beginning of 1988 to May 30, 1998. When a country's law underwent more than 1 legislative or judicial change, only the most recent is indicated. It is hoped that information given in this chart is comprehensive and exact, but in view of problems of documentation and interpretation of new laws, the authors would welcome any corrections.

L-*n* means the indication is limited to abortions done during the first *n* weeks or months (as indicated) of pregnancy. Countries generally measure pregnancy from the first day of the last menstrual period, in accordance with standard medical practice. In some countries, gestation limits may be extended when the pregnancy is not recognized or diagnosed earlier or when there are grave reasons to do so.

[-]Indicates a regressive law. Chile: removed risk-to-life indication. El Salvador: removed risk-to-life indication. Japan: removed fetal handicap indications. Poland: removed social indication.

[a]It is presumed that when legislation provides a health indication for abortion, the legislation includes grounds of both physical and mental health in accordance with generally prevailing medical usage. Mental health is excluded, however, where legislation qualifies "health" by "physical" or like expression. A mental health indication may accommodate rape and, for instance, apprehension of severe fetal abnormality when such indications are not accommodated in their own right. When such indications are not accommodated in their own right, they are not indicated in the chart. The grounds for a health indication may vary from a "threat" or "risk" to "grave endangerment" or "permanent injury."

[b]The grounds for this indication may range from "fetal abnormality" to "incurable fetal deformation."

[c]Where the law explains that account can be taken of the woman's social or economic circumstances or environment in deciding to prosecute or in determining the effect of a pregnancy on the health of the woman, this column is marked.

[d]The "on request" column includes those countries that have changed their laws to enable women who are "in distress" to obtain abortions because the determination of distress is made by the woman herself.

[e]Where the law prohibits abortion under any circumstances, including to save the life of the woman, as in Chile and El Salvador, it is unclear whether a court would recognize a defense of necessity when a woman's life is at stake or permit the procedure under the doctrine of double effect.

[f]Additional indications for abortion exist, including age (16 years old or younger or 45 years or older), as in Estonia; AIDS or seropositivity for HIV indication—the maternal or fetal health indication covers AIDS or seropositivity for HIV, as in Guyana; contraceptive failure, as in Guyana; crisis indication—the mental health indication covers situations in which the pregnant woman is in a "serious crisis," as in Hungary; disease indication—the physical and mental health indication covers situations in which the woman is suffering from an indicated disease, as in Mongolia.

[g]Depends on interpretation of "necessary treatment."

[h]Depends on interpretation of "necessary to accomplish a legal benefit or to prevent an expected harm."

CEDAW expressed similar concern about harms to women's health associated with punitive abortion legislation, denying services in cases involving rape in countries such as Luxembourg[56] and Venezuela.[57]

The Human Rights Committee identified high rates of maternal mortality caused by clandestine abortions in Colombia[58] and expressed the same concern about high maternal mortality in the Sudan.[59] Concerning Senegal, the committee "continues to be especially disturbed at the rate of maternal mortality which results from . . . the strict prohibition of abortion . . . [and] urges the state party to abolish practices prejudicial to women's health and to reduce maternal mortality."[60] The committee found that in Peru, criminalizing abortion of pregnancy caused by rape is equivalent to inhumane treatment of women and may violate equal respect for rights of men and women, and women's right to life, protected by the Political Covenant. The committee recommended that "the provisions of the Civil and Penal Codes [of Peru] should be revised in the light of the obligations laid down in the Covenant."[61] In contrast, in Brazil, where abortion is legal in cases of rape, a women's health organization has developed collaborative arrangements with the police to investigate rape complaints and to provide timely access to justified abortion services.[62]

Events seemingly unrelated to abortion have shown denial of rights to legal abortion in a more oppressive and dramatic context. The systematic, politically and ethnically motivated rape of women in territories of the former Yugoslavia is now included in trials for war crimes.[63] The rapes were often followed by the equally vicious denial of victimized women's requests for abortion, also referred to as *forced maternity.*[64] The 1995 Beijing Platform for Action comprehensively condemned "forced pregnancy" as a violation of women's rights,[65] and it is recognized as a war crime.[66]

Forced pregnancy describes not only denial of legal abortion when pregnancy follows rape but also state denial of abortion services when pregnancy termination is requested on other indications.[67] It imposes an

unparalleled burden on women. No other circumstance requires unwilling individuals to provide the resources of their bodies for the sustenance of others—for instance, as organ, bone marrow, or blood donors—and legal compulsion that they do so would quickly be condemned as a human rights violation.[68] The requirement that women against their will serve their unborn is discriminatory on the grounds of sex, reflecting disrespectful attitudes toward pregnant women, because neither women nor their husbands can be legally compelled to afford their born children necessary blood or bone marrow transfusions or other resources available from their bodies.

Legal amendments have been proposed to inhibit choice of legal abortion by declaring the religiously grounded belief that human life begins at conception. Debate leading to the Convention on the Rights of the Child, adopted by the UN General Assembly in 1988, concluded by omitting any legally binding statement to this effect. The preamble states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth."[69] No convincing evidence indicates that this phrase is intended to preclude women's rights; in fact, it might require states to provide prenatal care. Nevertheless, the debate inspired some opponents of choice to press for national declarations in constitutions. For example, the 1991 Czech Charter of Fundamental Rights and Freedoms contains a provision that human life is "worthy of protection already before birth,"[70] and at least one Mexican state, Chihuahua, has amended its state constitution to protect life from the moment of conception.[71] Such provisions do not necessarily prevail over women's rights to therapeutic abortion but furnish countervailing interests that need to be addressed. Attempts to insert similar provisions in constitutions were defeated in, for instance, Argentina,[72] Brazil,[73] and Colombia.[74] Moreover, the 1991 Constitution of Slovenia protects the right to free choice of maternity.[75]

Under laws that recognize women's choice, subject to various conditions and restrictions, health service providers' rights of conscientious objection to participation in abortion are also recognized. For instance, in 1989, Denmark amended its abortion law explicitly to recognize a right of conscientious objection for physicians, nurses, assistant nurses, and midwives and for persons training for these positions.[76] Such clauses are, however, inapplicable when the woman's life is at stake, which is made explicit in the Guyana law.

Human rights of conscience warrant the greatest possible protection, as do the conscientious rights of pregnant women. Professional codes of medical, nursing, and related ethics frequently profess the primacy of patients' health, suggesting a dedication to the priority of patients' well-being over conflicting interests of health care providers. The CEDAW observed that the liberal Italian abortion law, upheld by the Constitutional Court in 1988,[77] has been ineffective to make services available to women in southern Italy. The government has not balanced women's rights against the rights of doctors and hospital personnel, who invoke their right to conscientious objection to deny abortion services.[78] CEDAW expressed similar concern regarding the report of Croatia.[79]

Human rights to freedom of religion, freedom of speech, and freedom of association have been invoked by antichoice activists who want to demonstrate[80] and to inform women who are about to enter abortion clinics of reasons why they should not terminate their pregnancies. Some activists engage in offensive conduct, but the more conscientiously motivated activists exercise the right to engage in prayerful protest and to offer "sidewalk counseling" of women.

Domestic courts in several countries have balanced competing human rights to autonomy, conscience, and protection against intimidation of both women seeking abortion services and antiabortion activists. For example, courts in England,[81] Canada,[82] and New Zealand,[83] and courts and legislatures in the United States[84–86] have found compromises between the interests of such women and activists, such as by approving measured zones around abortion facilities within which activists must not obstruct access of women or service providers, including counselors. Similar protective zones have been legislated in France.[87] Both opponents and supporters of abortion rights have shown legal resourcefulness; the former have invoked an array of civil and political rights to support their physical intervention between women and abortion facilities, and the latter have successfully invoked laws against stalking,[88] property trespass,[83] and racketeering[89] but not necessarily conspiracy.[90]

Human rights to information about abortion services legally available outside a country, and freedom to travel, have been recognized following litigation involving Ireland. The right to information within Ireland about abortion services legally available outside Ireland was recognized by the European Commission[91] and the European Court of Human Rights[92] following 2 judgments of the Supreme Court of Ireland.[93,94] These judgments had prohibited the publicizing of abortion services that were lawfully available in Britain on grounds not accommodated in Irish law. A further decision of the Supreme Court of Ireland, which reversed lower-court decisions involving a 14-year-old girl pregnant by rape, held that the Irish Constitution permitted travel to receive safe, legal abortion because of a "real and substantial risk to the life, as distinct from the health, of the mother, which can be avoided only by the termination of her pregnancy."[95]

Public condemnation of the way in which Irish law had dealt with these cases led to 2 amendments of the Irish Constitution in 1992. Amendment 13, which recognized general freedom to travel,[96] and Amendment 14, which recognized freedom of information relating to services lawfully available in another state,[97] were approved by a national referendum in 1992. The Supreme Court[98] constitutionally upheld implementing legislation permitting information on abortion to be made available, but not promoted or advocated,[99] to individual women and the general public. After a more recent decision of the High Court that permitted a 13-year-old girl pregnant by rape to travel to Britain for an abortion,[100] the Irish government established an interdepartmental working group to prepare a Green Paper, the first step in the process of drafting a new law to permit abortion in Ireland.[101]

## *Administrative Procedures*

Administrative requirements regarding third-party authorization of abortion by male partners, parents, doctors, or hospital committees, and mandatory counseling and reflection delays, have been scrutinized for their effect on health and on how they might infringe the human rights of women. For the last decade, as indeed for many years before,[102] courts in Australia,[103] Canada,[104] Italy,[105] Norway,[106] Scotland,[107] and the United States[108] have uniformly rejected claims that abortions requested by women are unlawful without authorization of male partners. Legislation in Guyana and South Africa explicitly protects women's abortion choices from third-party veto, and Equatorial Guinea's law allows a husband's or guardian's objection to be overridden by a court. CEDAW has requested Turkey to review the requirement of partner authorization in its abortion law to ensure compliance with the Women's Convention.[109]

Parental authorization clauses, however, have been supported in the United States.[110–112] The US Supreme Court has stated that parental notification requirements that do not include judicial bypass provisions are unconstitutional,[110] and the Supreme

Court of California recently found the state's parental consent law to violate minors' right to privacy under the California constitution.[113] The 1995 law in Guyana states that physicians are not required to seek consent of or even to notify a minor's parents of her request for abortion.

Most third-party authorization laws concern physicians or hospital committees. Several laws require second medical opinions, such as in Belgium for abortions after the first trimester. In Hungary and Poland, abortion on the grounds of rape requires certification by forensic agencies or public prosecutors. Saudi Arabian law requires approval by a hospital committee of at least 3 specialists, and in Albania and Bulgaria, medical indications must be approved by a special medical commission. In contrast, the Supreme Court of Canada held therapeutic abortion committees unconstitutional because their decisions might apply "criteria unrelated to [women's] own priorities and aspirations."[114] Moreover, feminist commentators have elucidated the gendered nature of such committees.[115]

Counseling or consultation is mandatory in the legislation of Albania, Belgium, Cambodia, Germany, Guyana, Hungary, Jersey, and Poland. In Germany, nationals returning from obtaining abortions in the Netherlands were often prosecuted for obtaining abortions that were unlawful by German law,[116] and in one instance in 1991, a woman was detained at the border, forcibly examined, and then charged with unlawful abortion because she evaded the West German law.[117,118]

Germany's counseling provisions have been the focus of an enduring debate.[119] The German law requires women to undergo counseling that favors the "protection of the unborn child" at a licensed counseling center 3 days before having an abortion. Women must produce a certificate as proof that they have received such counseling. In January 1998, Catholic Church–sponsored counseling centers accepted an "urgent request" from the Vatican to stop issuing counseling certificates. The church in Germany has indicated, however, that the centers, which make up approximately 15% of all counseling centers in the country, will continue to offer pro-life counseling.[120]

Many countries that require counseling have also legislated waiting periods for women's reflection. For instance, in Belgium, Germany, Hungary, Jersey, and Poland, a mandatory waiting period of between 3 and 7 days is required after counseling before an abortion may be performed. Since the US Supreme Court ruled in 1992 that abortion laws requiring a 24-hour reflection delay following mandatory counseling are constitutional,[121] several states have introduced waiting periods into their abortion laws. Supporters of reflection delay regimes argue that it is important that women have adequate time to make a free and informed decision about abortion, whereas opponents consider a legislated waiting period paternalistic and an unnecessary barrier to access that is not required for other medical procedures. Waiting periods often require an extra visit to the abortion provider, adding additional time, stress, and financial cost to obtaining an abortion. Further, waiting periods may lead to more second trimester abortions, which pose greater health risks and tend to be more expensive than earlier procedures. A study of abortion rates in Mississippi before and after the enactment of a 24-hour mandatory delay suggests that concerns over waiting periods are valid. After the law in Mississippi went into effect, the abortion rate declined 14% relative to neighboring states that did not have mandatory delays, while the absolute number of second trimester abortions increased.[122]

## *Conclusion*

Developments in abortion law since 1988 have shown a tension among punitive, health, and human rights approaches to legal reform. These 3 approaches exist in all countries and are not mutually exclusive. The tendency to use criminal law to punish and stigmatize disapproved behavior remains, but this tendency is waning because of an increased understanding, due in part to quantitative and qualitative research, that this approach is dysfunctional. Most countries have extended the grounds for abortion to preserve women's health and welfare, and some countries now cover or subsidize the cost of the procedures in national health services or insurance programs. A substantial number of countries have applied a human rights rationale because of a growing recognition, in part through the Cairo and Beijing conferences and the work of the human rights committees, of the importance of the human rights of women in general and the specific right of reproductive self-determination. □

## Contributors

L. E. Bliss analyzed files that had been prepared by R. J. Cook and B. M. Dickens for earlier studies and gathered related literature, legislation, and judicial decisions from various countries. R. J. Cook and B. M. Dickens prepared a first draft of the paper. All 3 authors contributed to the penultimate draft and to checking and updating data. R. J. Cook and B. M. Dickens completed the final submission.

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